**NUBC Meeting**
**April 4-5, 2017**
**AMA Headquarters**
**330 N. Wabash Ave.**
**Chicago, IL 60654**
**TENTATIVE AGENDA**
(as of 3/28/17)

**April 4, 2017 - Open NUBC Meeting - Grand Canyon Conference Room**
(Dress: Business Casual)

| | |
|---|---|
| 1:00 - 1:15 pm | Welcome and Introductions |
| 1:15 - 1:30 | Review and Approve Minutes<br>• March 14, 2017 Conference Call |
| 1:30 - 3:00 | Old Business<br>Status of Shorter Duration/More Frequent Hemodialysis Policy (Revenue Code 0826, Value Code 84, Condition Code 86)<br><br>New Business/Other Issues/Changes<br>• Off-campus Provider Based Outpatient Departments (PBD)<br>  o Background -- New Site-neutral Payment Policy (Attachment 1)<br>  o Billing for "Non-excepted" Services<br>  o PO and PN Modifiers,<br>  o Reporting of Service Location(s) (UB-04 and 837)<br>  o Related Changes to the PECOS and FISS Systems<br>  o Development of FAQ<br><br>• New Occurrence Code for Original Hospice Election or Revocation Date (Attachment 2)<br><br>• Assignment of Benefits Certification Indicator - UB-04/7030 837 CLM08 Synchronization (Attachment 3)<br><br>• Discussion of 7030 Topics |
| **3:00 - 3:15** | **Break** |
| 3:15 - 4:30 | New Business/Other Issues/Changes – Continued |

**(OVER)**

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**TENTATIVE AGENDA**
(as of 3/28/17)

**April 5, 2017 - Open NUBC Meeting - Grand Canyon Conference Room**
(Dress: Business Casual)

**8:00 - 8:30 a.m.** **Breakfast**

8:30 - 10:15 Other Issues:
- State Issues

**NUBC/NUCC Joint Meeting**

10:15 a.m. I. NCVHS Plans for 2017
- HPID
- Predictability Roadmap
- Review Committee

10:30 a.m. II. Improvements Incorporated into the 7030

11:00 a.m. III. Prior Authorization

**12:00 p.m.** **Lunch**

**NUCC Open Meeting** (Agenda available from NUCC)
1:00 - 5:00 p.m.

**Off-campus Provider Based Outpatient Departments (PBD)**

On November 1, 2016 CMS released the calendar year (CY) 2017 outpatient prospective payment system (OPPS)/ambulatory surgical center (ASC) final rule. In addition to updating the OPPS and ASC payment weights and rates, the rule implements the site-neutral provisions of Section 603 of the Bipartisan Budget Act of 2015 (BiBA), which requires that, with the exception of dedicated emergency department (ED) services, services furnished in "new" off-campus PBDs (those that began furnishing covered outpatient department services on or after 11/2/2015) will no longer be paid under the OPPS. Instead, hospitals will be paid under the physician fee schedule (PFS) at newly established rates for these services. For 2017, the payment rate for these services will generally be 50 percent of the OPPS rate. In addition, CMS finalized its proposal that the relocation of an existing PBD will result in its losing its excepted status.

Hospitals will continue to bill on the institutional claim (UB-04/837I) using a new claim line modifier "PN" to indicate that the service is a "non-excepted" item or service. For CY 2017, the payment rate for most of these items and services will generally be 50 percent of the OPPS rates.

The use of modifier "PN" will trigger a payment rate under the Medicare Physician Fee Schedule. CMS expects the PN modifier to be reported with each nonexcepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

Excepted off-campus provider-based departments of a hospital will continue to report existing modifier "PO" (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services furnished. Use of the off-campus provider-based department (PBD) modifier became mandatory beginning January 1, 2016.

Neither the PO nor the PN modifier is to be reported by the following hospital departments:

- A dedicated emergency department as defined in existing regulations at 42 CFR 489.24(b)
- A PBD that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital as defined under 42 CFR 413.65

Discussion:

PBD Address

In the case of off-site hospital outpatient departments, the Billing Address (which is the hospital) will not be the same as the service location.

There is a now need to segregate the service address from the billing address because they are different. Some MACs have had hospitals add all alternate addresses for their off-site locations to the enrollment. The MACs will be editing within PECOS and the FISS system to ensure that all alternate service addresses are enrolled and that the address that is sent in as the Service Location is associated with the Billing Provider on record.

***FOR DISCUSSION PURPOSES ONLY***

On the UB-04, FL01 is defined as the billing provider name (whose NPI is reported in FL56) and the address of the service location. Therefore, FL01 is tied to the billing provider's NPI. The service location name and address are reported in a separate location in the 837I (Loop ID 2310E) as well as its NPI when it is not a component or subpart of the Billing Provider entity (i.e., it must be must be external to the entity identified as the Billing Provider). For example, this would be the case when the physician goes to the nursing home to see the patient. The UB-04 currently does not accommodate this second NPI.

Service Lines

CMS does not expect off-campus PBDs to report both the PO and PN modifiers on the same claim line. However, if services reported on a claim reflect items and services furnished from both an excepted and a nonexcepted off-campus PBD of the hospital, the PO modifier should be used on the excepted claim lines and the PN modifier should be used on the nonexcepted claim lines.

The excepted and a nonexcepted off-campus PBD both will have service location addresses. Services may be provided in both locations on the same day. The 837I accommodates only one service location address. How is the billing to be handled? Separate claims?

# NUBC CHANGE CONTROL REQUEST

**(Return to Matt Klischer (mklischer@cms.hhs.gov) x 67488, N2-10-25)**

**DATE: March 24, 2017**

**REQUESTOR ORGANIZATION NAME: Division of Institutional Claims Processing (DICP), Provider Billing Group (PBG); Center for Medicare (CM), CMS**

**CONTACT PERSON: Wil Gehne or Charles Nixon**

**E-MAIL ADDRESS: wilfried.gehne@cms.hhs.gov, charles.nixon@cms.hhs.gov**

**TELEPHONE NUMBER: 410-786-6148, 410-786-9183**

**PERSON(S) WHO WILL PRESENT THE CHANGE TO THE NUBC: Fred Rooke, Wil Gehne (by phone)**

**DRAFT INSTRUCTION NUMBER (PLEASE ATTACH): Pending**

**DESCRIPTION OF ACTION REQUESTED (e.g. additional occurrence code needed):**

Create a new occurrence code effective January 1, 2018 to identify original hospice election or revocation date when the hospice is submitting a correction to dates.

Short definition: “Original Hospice Election or Revocation Date.”

Usage Note: Used when the hospice is submitting a correction to the election date reported on a previous 08xA Type of Bill or the revocation date on a previous 08xB Type of Bill. The hospice reports the correct dates in FL6 From/Through and the original date in this occurrence code.

**CAUSE FOR CHANGE (regulatory, data collection, other):**

Currently, if a hospice submits an incorrect election date on a Notice of Election (NOE - TOB 08xA) the hospice needs to submit a cancellation of the notice (TOB 08xD) and then a new NOE to provide the correct date. If the hospice submits an incorrect date on a Notice of Revocation/Termination (NOTR – TOB 08xB), they must submit a discharge claim conforming to the incorrect date and then adjust that claim with the correct revocation date in occurrence code 42.

Both cases require two transactions, which can impede the hospice’s ability to comply with Medicare regulations requiring submission of these notices within 5 days of admission or discharge. In the case of NOEs, cancellation of the hospice benefit period in Medicare systems erases the NOE receipt date used to enforce those regulations. This

can result in administrative effort for both the hospice and Medicare in processing exception requests or in denial of payment for days of hospice care.
Medicare is developing changes to our systems to accept NOEs and NOTRs via electronic data interchange and to restructure hospice benefit period data in our systems to better support various Medicare policies. Through our analysis of these changes, Medicare identified an opportunity to improve the processing of corrected dates. A new NOE or NOTR with a different date and no other identifier would look like a duplicate submission and be rejected. However, if the proposed occurrence code were available, the code would identify the submission as a date correction and allow Medicare systems to match the correction to the right hospice benefit period based on the matching original date.

We believe such a change would reduce administrative burden on both hospices and Medicare Administrative Contractors. The date change would be accomplished in a single transaction and the NOE receipt date would not be affected.

**IMPACT STATEMENT (current form/instruction impacted, funding approved, implementation cost estimate, contractor operations impacted):** A change request for the January 2018 Medicare systems release would be needed to implement this new code. Costs and operations impacts will be assessed during the clearance process of that CR.

**NOTE: Attach any documentation that clarifies this request, including documentation to support a request that is a result of a CMS mandate.**

*******DO NOT COMPLETE THIS SECTION*******

**Action Taken:**

**Final Disposition:**

**ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR**
**UB-04/7030 837 CLM08 SYNCHRONIZATION**

**UB-04:**

**Form Locator 53: Assignment of Benefits Certification Indicator**
**Definition: Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.**
**Notes: Health plans that have arrangements with affiliate health plans in different states may utilize this code to make payments to the provider rather than the insured individual. This element answers the question whether or not the insured has authorized the plan to remit payment directly to the provider.**

**The presence of an assignment does not permit release of medical information about a patient.**

| **Code Structure:** | **N** | **No** |
|---|---|---|
| | **W** | **Not Applicable (Use code 'W' when the patient refuses to assign benefits.)** |
| | **Y** | **Yes** |

**5010 837**

REQUIRED CLM08 1073 **Yes/No Condition or Response Code** O 1 ID 1/1

Code indicating a Yes or No condition or response

SEMANTIC: CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.

IMPLEMENTATION NAME: **Benefits Assignment Certification Indicator**

**This element answers the question whether or not the insured has authorized the plan to remit payment directly to the provider.**

| CODE | DEFINITION |
|---|---|
| N | No |
| W | Not Applicable<br>Use code 'W' when the patient refuses to assign benefits. |
| Y | Yes |

**7030 837**

REQUIRED CLM08 1073 **Yes/No Condition or Response Code** O 1 ID 1/1

Code indicating a Yes or No condition or response

SEMANTIC: CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.

INDUSTRY NAME: **Benefits Assignment Certification Indicator**

**This element is for reporting whether the patient has or has not assigned benefits to the provider.**

| CODE | DEFINITION |
|---|---|
| N | No<br>Use when the patient neither agreed nor refused to assign benefits to the provider. |
| W | Not Applicable<br>Use when the patient actively refused to assign benefits |
| Y | Yes |

**The issue is UB/7030 837 synchronization. Options:**

1. **Accept the language change and modify the UB-04.**
2. **Reject the language change, keep the UB-04 as is and recommend that 7030 revert back to 5010.**
3. **Propose edits to the language change and if accepted, modify the UB-04 accordingly.**
4. **Change the usage rule to refer to the NUBC Manual.**